



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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July 25, 2008

Christie Roach  
Legacy Hospice  
680 South Progress Avenue Suite 2A  
Meridian, Idaho 83642

Provider #131546

Dear Ms. Roach:

On **May 29, 2008**, a Complaint Survey was conducted at Legacy Hospice. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00003534**

**Allegation #1:** The Hospice did not provide baths to patients who lived in Assisted Living Facilities(ALFs) for extended periods of time, and failed to communicate to ALF staff about the cares they were providing.

**Findings:** An unannounced visit was made to the agency 5/27 through 5/29/08. The agencies policies, Quality Assurance Performance Improvement (QUAPI) program, and eleven patient's medical records were review. Staff were interviewed.

Eleven records were reviewed of patients who lived in ALFs. Six of the eleven records had no documented evidence that patients were showered or bathed for up to 14 days. Further, the Hospice's Plan of Care (POC), and the ALF's Negotiated Service Agreements (NSA) for four of the six patients did not uniformly match on whose responsibility it was to assure that patients were bathed. Four POCs and NSAs stated, it was the other agency's responsibility to bathe the patient. The records did not contain documented evidence the hospice agency had effectively communicated with the ALF staff as to whose responsibility it was to shower or bathe the patients until it was discovered that patients went for an extended period of time without a bath or shower.

On 5/28/08 at 5:00 PM, the Hospice Administrator stated that bathing and communication with ALF's staff was identified as problem and the agency had, as of 5/9/08, started a "Quality Improvement Project" to address the problem.

The agency's "Quality Improvement Project", dated 5/9/08, documented the agency had identified that some patients in ALFs were not being bathed. The agency had developed a plan and was monitoring the effectiveness of that plan. Nine "active" patient records reviewed, documented improved compliance with the bathing or showering of patients for the month May to the date of the survey.

The agency's "Quality Improvement Project", dated 5/21/08, documented the agency had identified communication with facility staff as a problem. The agency had developed a plan and was monitoring the effectiveness of that plan. In fact nine of the "active" patient records reviewed, documented improved communication with ALF staff with regards to the bathing or showering of patients for the month May to the date of the survey.

Substantiated. However, the facility was not cited as they acted appropriately by identifying the problem and instituting a Quality Improvement Project to improve the agency's performance with the bathing of patients and communication with ALF staff.

**Conclusion:** Substantiated. No deficiencies related to the allegation are cited.

**Allegation #2:** Nursing staff failed to supervise Certified Nursing Assistants (CNAs) to ensure that baths were provided to patients living in ALFs.

**Findings:** An unannounced visit was made to the agency 5/27 through 5/29/08. The agencies policies, Quality Assurance Performance Improvement (QAPI) program, and eleven patient's medical records were review. Staff were interviewed.

Eleven records were reviewed of patients who lived in ALFs. Six of the eleven records had no documented evidence that patients were showered or bathed for up to 14 days. The records did not contain documented evidence the hospice agency nurse had effectively supervised CNAs in regards to showering or bathing patients.

On 5/28/08 at 5:00 PM, the Hospice Administrator stated that supervision of CNAs and the bathing of patients in ALFs was identified as problem and the agency had, as of 5/9/08, started a "Quality Improvement Project" to address the problem.

The agency's "Quality Improvement Project", dated 5/9/08, documented the agency had identified that some patients in ALFs were not being bathed and "CNA supervision improvement" was needed.

The agency had developed a plan and was monitoring the effectiveness of that plan. Nine "active" patient records reviewed, documented improved compliance with CNA supervision.

Substantiated. However, the facility was not cited as they acted appropriately by identifying the problem and instituting a Quality Improvement Project to improve the agency's performance with CNA supervision.

**Conclusion:** Substantiated. No deficiencies related to the allegation are cited.

**Allegation #3:** Nursing staff were to exaggerate their patients' conditions documentation.

**Findings:** An unannounced visit was made to the agency 5/27 through 5/29/08. The agencies policies, Quality Assurance Performance Improvement (QAPI) program, and eleven patient's medical records were review. Staff were interviewed.

Eleven records were reviewed of patients who lived in Assisted Living Facilities. Nursing visit notes were reviewed for patient status documentation at the time of the visits. One record showed a patient who experienced periodic episodes of decreased level of consciousness. Each occurrence lasted for several hours. During each episode the on call Hospice nurse was notified and visited the patient. Review of the nursing visit notes on these occasions showed documentation based on patient observation and assessment. These notes showed the patient to be cool, clammy, having a slow heartbeat and being non-responsive to verbal or mild physical stimulus. All documentation reviewed was appropriate to the patient's physical condition at the time. Documentation also included contact with the doctor as well as education of ALF staff relating to their care of the patient during these episodes. Nursing documentation did not show exaggeration of the patient's condition.

**Conclusion:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #4:** Nursing staff failed to communicate to ALF staff about morphine that was brought into the facility by the hospice agency.

**Findings:** An unannounced visit was made to the agency 5/27 through 5/29/08. The agencies policies, Quality Assurance Performance Improvement (QAPI) program, and eleven patient's medical records were review. Staff were interviewed.

Eleven records were reviewed of patients residing in Assisted Living Facilities. Medication sheets were reviewed as were doctor's order sheets for medications orders. One record showed a patient with a doctor's order for, "Morphine Sulfate 20mg/ml. Give 0.25 ml SL (under the tongue) for pain or SOB (shortness of breath)".

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This order was dated 3/1/08 and was noted by the administrator of the Assisted Living Facility.

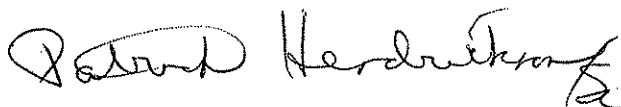
This patient's medications were supplied by an outside pharmacy and delivered by certified delivery. The delivery records were reviewed and showed each shipment of Morphine Sulfate for the patient was signed for by an Assisted Living staff member. These delivery records were provided by the QI Director of the Hospice during an interview on 5/27/08 at 10:00 AM.

Assisted Living staff were aware that there was Morphine Sulfate in the facility for the patient. They were also aware of the ordered dose.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As two of the allegations were substantiated, but were not cited, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



PATRICK HENDRICKSON  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

PH/mlw